STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF MENTAL RETARDATION SERVICES
ANDREW JACKSON BUILDING, 15TH FLOOR
500 DEADERICK STREET
NASHVILLE, TENNESSEE 37243
December 17, 2004

MEMORANDUM

TO: Agency Directors
ISC Agency Directors
Clinical Services Providers

FROM: Stephen H. Norris
Deputy Commissioner
Division of Mental Retardation Services

SUBJECT: Implementation of New Waivers

We have received informal notification from CMS that the waivers will be renewed effective January 1, 2005. We expect that the new Self Determination waiver will also be approved for a January 1 start date.

This memo contains information and instructions about what your agency will need to do in order to bill for services under the new waivers. Workshops to review all changes with providers are being arranged for mid-January. Training will be held at the regional office locations and will take approximately a day and a half. There will be an overview of all changes for everyone followed by service specific sessions. More information will follow shortly.

Statewide and Arlington Waivers

1. **Service Definitions**
   Attachment 1 is the service definitions that must be followed under the new waivers. Until the new Provider Manual is available, providers must, at a minimum, deliver services that meet these definitions. This means that you will be accountable for compliance with these definitions beginning on January 1.

   Some of the highlights of changes in service definitions are:
   - The definition of Day Services is now a single service that includes facility based, community based and employment options. The unit is a day instead of an hour.
   - Service limits have been set for a number of services.

- Clinical Services are almost exclusively required to be face to face services.
- Several new services have been added including Medical Residential Services, Orientation and Mobility Services and Follow Along Services.
- Nursing Assessment is not a separate, billable service.

Please review all service definitions carefully. If you have questions about the service definitions, please call Donna Allen at 615-532-6540 or email her at donna.allen@state.tn.us.

2. **Provider Manual**

You will be expected to be in compliance with new requirements contained in the Provider Manual by ninety (90) days from receipt of it with a couple exceptions. The timeline for developing prevention plans is120 days after manual receipt. The new process for requesting review of investigations will also be in effect in 120 days. New requirements for support planning will be implemented as ISPs become due beginning 90 days after receipt of the Provider Manual. Please see below "Support Planning and Coordination" for more explanation. You will not be held responsible for new requirements during QA surveys until after that time

3. **Rates, Billing and Documentation Requirements**

The new rate structure will become effective for services delivered in January. There are four attachments related to the new rate structure: Attachment 2 is the final rate schedule for all services. Attachment 3 is the final definitions for the rate levels. Attachment 4 is the staffing plan requirements. Attachment 5 is a spreadsheet with cost centers, rate levels, and rates for the individuals you serve in residential and/or day services.

Rates for Residential and Day Services

During the course of reviewing rate levels over the past several months for each individual with each agency, several adjustments were made to rates and levels definitions. As a result, particularly if we talked to your agency early in the process, the rate level and/or rates may have changed for some of the people you serve. You may also have added new people or had people leave or have changed home configurations since then. So please review the spreadsheet carefully. This is the information we will load into the payment system unless we hear from you before January18, 2005. (If you would like an electronic copy of the spreadsheet for your agency, please request it through an email to Lucia Beiler at lucia.beiler@state.tn.us so that we can be certain we have your correct email address.)

Day Services are provided as described in the person's ISP. However, in order to prepare for billing, for Day Services we based the anticipated service sites contained in the spreadsheet on the individual's current cost plan--except that we added a community based service cost center for everyone except individuals in Follow Along. Follow Along may not be combined with any of the other Day Services. So, if an individual currently has a cost plan for only day habilitation, we added a cost center for community based services to it. If an individual currently has only community based services, we maintained that. If an individual has only an employment service (except for Follow Along) we added a cost center for community based services. We did not add an employment cost center if an individual is not currently receiving an employment service. If you believe that a cost center will be required that is not reflected on the spreadsheet, you must notify the regional office. You will not be able to bill for a service at a site that is not entered into the payment system.

If you believe the rate level or rate for either Day or Residential Services is incorrect, or have any other issues that are individual-specific for any of the people you serve, please email Brian Dion at brian.dion@state.tn.us with the individual's name and information about why the rate or rate level is incorrect. He will be back in the office on January 5 and will contact you between January 5 and January 17 to correct any problems. If you have other questions about the information on the spreadsheet, such as site codes, please contact the regional office.

Once we have entered the information into the payment system, you will receive in early February the usual "turn-around" document for January billing purposes. We do not anticipate an interruption to the payment schedule for January services. However, should a problem occur, we will make payment to your agency at the usual time based on our best estimate of what is owed and then settle the difference at a later date.

Staffing Plans

As you know, the new rate structure is not built on prescribed staffing ratios. Instead, the provider is responsible for developing a staffing plan for each residential site and day service site that meets the health and safety needs of the individuals served and ensures that outcomes for the individuals are achieved. You may not, however, change the current staffing ratio in any home or day service until you have a staffing plan in place. If you do not anticipate changing the staffing pattern for a home or day service, you must have a staffing plan in place within 90 days of receipt of the new Provider Manual.

Staffing plans do not require DMRS approval; however, staffing plans will be reviewed as part of the annual quality assurance surveys.

Documentation of Day and Residential Services for Billing Purposes

The documentation that will accompany your billing is not changing significantly. However, the back up documentation that you maintain will change for some services. Only those services that require different documentation from before are addressed here.

The unit for Day Services has changed from one hour to one day. Only one rate for Day Service may be billed for the day. The rate billed for each day of service is determined by the site(s) for the service for the day. If an individual works at a community employment site for at least two hours of the Day Service, the appropriate supported employment rate is billed. Otherwise, the rate billed for the day is the appropriate rate for the site where the individual spent the majority of his time. Consequently, you must maintain time logs that indicate the time in and time out for each service site. Travel time between service sites does not count as time in any service site. As always, you may not bill for days that an individual does not participate in any day service. However, day services may be provided in the home when that is necessary or appropriate for the individual.

The daily notes for the Day Service must support the time spent in service sites as well as the implementation of the Day Service outcome(s) in the ISP.

Daily transportation to and from Day Services is included in the Day Services rate and does not count as time in Day Service. Transportation logs **are not required** by DMRS for daily transportation to and from Day Services. This does not, of course, change any requirements other agencies, such as the Department of Transportation, may have.

Transportation logs **are required** By DMRS for Individual Transportation Services.

Requirements and Documentation for Clinical Services

Physical Therapy, Occupational Therapy and Speech/Language/Hearing Therapy and Nutrition Services rates have transportation built in when applicable based on distance from the town of the agency site or the town where the therapist lives, whichever is closer to the consumer, to the town where the individual's service is provided (per Mapquest). This also applies to Orientation and Mobility Services.

Daily billing is limited to 1½ hours or to 3 hours for assessments for physical therapy, occupational therapy and SLH therapy. Nutrition is limited to 1-½ hours per day for any type of service.

Physical Therapy, Occupational Therapy and Speech/Language/Hearing Therapy and Nutrition Services must be provided face to face except that training may be provided either face to face or only with staff present as appropriate.

Training provided to direct support staff or the trainer designated by an agency may be billed as therapy hours.

Therapists are required to sign in and out at therapy locations and to make a brief note describing the therapy activity conducted. If the location of the therapy is at a site operated by another provider (day or residential service location), the sign in and note will be made in the consumer record at the location as indicated by the day or residential service providers. Hours may not be billed if this documentation is not present.

Co-treatment by therapists or therapist with nurses or behavior services providers requires that medical necessity for co-treatment is documented.

If you have questions concerning billing requirements for therapy services, please contact Karen Wills at 615-532-3063 or email her at karen.wills@state.tn.us.

Requirements and Documentation for Behavioral Services

Behavioral services are limited to face to face contacts. Attendance at meetings is not billable.

Behavior interventions designed to decrease challenging behavior and to increase replacement behavior shall be implemented and monitored through an approved behavior support plan with time-limited behavior change objectives.

Behavior providers are required to sign in and out at service locations and to make a

clinical contact note describing the service provided. If the location of the behavior service is at a site operated by another provider (day or residential service location), the sign in and note will be made in the consumer record at the location as indicated by the day or residential service provider. Hours may not be billed if this documentation is not present.

Behavior specialists must work under the supervision of a Behavior Analyst and may not bill for services unless this supervision is provided.

Training provided to direct support staff or the trainer designated by an agency may be billed as behavior service hours.

If you have questions concerning billing requirements for behavior services, please contact George Zukotynski at 615-532-1610 or email him at george.zukotynski@state.tn.us.

Requirements and Documentation for Support Planning and Coordination
In the new structure, there is a single rate for ISC services. Requirements for contacts for class members are not changed. Documentation requirements for billing are not changed.

New requirements will become effective as new plans are developed and implemented over the first year of the waivers. This means that all providers must implement new assessment and planning processes in a manner that ensures that any plan due after 90 days of implementation of the provider manual is in compliance with the new requirements and on the revised format. All plans due 90 days after implementation of the new provider manual must be submitted to the appropriate Regional Office for approval and service authorization. The use of the old format or separate service requests after that point is unacceptable. Required documentation forms must be in effect with reporting to the respective agency executive director and DMRS no later than 90 days after implementation of the new provider manual. Any ISC hired after implementation of the provider manual must meet revised training requirements and pass certification. DMRS staff will be working with providers to develop a schedule for certification of ISCs hired prior to implementation of the new manual.

Self Determination Waiver
Attachment 6 is an overview of the SD Waiver and the service definitions. The service definitions differ from those contained in the Statewide and Arlington Waivers in several ways. First, there are no residential services available in the SD Waiver. Individuals who require residential services will be enrolled in the Statewide Waiver. Second, because there is an overall cap of $30,000 in the SD Waiver, there are no service specific service limits. Third, many of the services may be self-directed, that is purchased, supervised, and paid (through the Financial Administrator) by the individual. Fourth, there are additional services not included in the other waivers including Support Brokerage, Financial Administration and Participant Designated Goods and Services.

For services that are not self-directed, billing and payments will be done in the same manner as with the other two waivers. Rates for applicable services included in the other waivers will apply to SD Services. For self-directed services, billing will be managed by the Financial Administrator and rates negotiated by the individual not to exceed the published rates for like services.

Updates on the status of the SD Waiver and provider requirements will follow. Training for providers on the Self Directed Waiver will be held after the completion of the Participant and Provider Manual.

c: Alan Bullard
Kathleen Clinton
John Craven
Lucia Beiler
Adadot Hayes
Fred Hix
Larry Latham
Central Office Program Directors

Attachment 1

Service Definitions
Statewide and Arlington Waivers

Environmental Accessibility Modifications - Environmental Accessibility Modifications shall mean only those interior or exterior physical modifications to the enrollee's place of residence which are required to ensure the health, welfare, and safety of the enrollee or which are necessary to enable the enrollee to function with greater independence.

Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning; construction of an additional room) are excluded from coverage. Any modification which is not of direct medical or remedial benefit to the enrollee is excluded from coverage. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.

Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per enrollee per 2 year period.

Individual Transportation Services – Individual Transportation Services shall mean non-emergency transport of an enrollee to and from approved activities specified in the plan of care. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge should be utilized.

An enrollee receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training. Enrollees who receive Respite, Behavioral Respite Services, or Personal Assistance shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite, Behavioral Respite Services, or Personal Assistance is being provided.

Individual Transportation Services shall not be used for

- Transportation to and from Day Services;
- Transportation to and from supported or competitive employment;
- Transportation of school aged children to and from school;
- Transportation to and from medical services covered by the Medicaid State Plan/TennCare program;
- Transportation of an enrollee receiving a residential service, except as specified above for Orientation and Mobility Training and Behavioral Respite Services.

Individual Transportation Services are not intended to replace services available through the Medicaid State Plan/TennCare program.

Transportation of school age children to and from school is excluded.

Specialized Medical Equipment and Supplies and Assistive Technology - Specialized Medical Equipment and Supplies and Assistive Technology shall mean assistive devices, adaptive aids, controls, or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive, control, or communicate with the environment. Specialized Medical Equipment, Supplies, and Assistive technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician, nurse practitioner) based on an assessment of the enrollee's needs and capabilities and shall be furnished as specified in the plan of care. Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that specialized medical equipment and assistive technology which requires custom fitting meets the needs of the enrollee and may include training of the enrollee by a physical therapist, occupational therapist, or speech therapist to effectively utilize such customized equipment. Such assessment or training shall be limited to a maximum of 3 hours per enrollee per day.

Items not of direct medical or remedial benefit to the enrollee shall be excluded. Items that would be covered by the Medicaid State Plan/TennCare program shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.

Specialized Medical Equipment, Supplies and Assistive Technology is not intended to replace services available through the Medicaid State Plan/TennCare program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per enrollee per 2 year period.

Personal Emergency Response System – A Personal Emergency Response System shall mean a stationary or portable electronic device used in the enrollee's place of residence which enables the enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

Behavioral Respite Services - Behavioral Respite Services shall mean services that provide respite for an enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to

resolve the behavioral crisis. Behavioral Respite Services shall be provided in a setting staffed by individuals who have received training in the management of behavioral issues. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider. The Behavioral Respite Services provider may also accompany the enrollee on short outings for exercise, recreation, shopping or other purposes while providing Behavioral Respite Services care.

Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence. Behavioral Respite Services shall be limited to a maximum of 60 days per enrollee per year.

An enrollee receiving Behavioral Respite Services shall be eligible to receive Individual Transportation Services.

Behavior Services - Behavior Services shall mean (1) assessment and amelioration of enrollee behavior that presents a health or safety risk to the enrollee or others or that significantly interferes with home or community activities; (2) determination of the settings in which such behaviors occur and the events which precipitate the behaviors; (3) development, monitoring, and revision of crisis prevention and behavior intervention strategies; and (4) training of caregivers who are responsible for direct care of the enrollee in the prevention and intervention strategies. Therapeutic goals and objectives shall be required for enrollees receiving Behavior Services.

Behavior Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Training, or Speech, Language, and Hearing Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently. Behavior Services shall be provided face to face with the enrollee except that enrollee-specific training of staff may be provided when the enrollee is not present.

Behavior Services are not intended to replace services available through the Medicaid State Plan/TennCare program.

Day Services – Day Services shall mean individualized services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities. Therapeutic goals and objectives shall be required for enrollees receiving Day Services.

Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the enrollee's place of residence if there is a health, behavioral, or other medical reason or if the enrollee has chosen retirement. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day (i.e., between the hours of 7:30 a.m. and 6:00 p.m.), as specified in the plan of care. Day Services shall be limited to a maximum of 6 hours per day and 5 days per week up to a maximum of 243 days per enrollee per year.

Except for transportation to and from medical services otherwise covered through the Medicaid State Plan/TennCare program, transportation that is needed during the time that the enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day Services reimbursement rate: Transportation to and from the enrollee's place of residence to Day Services shall be the responsibility of the Day Services provider. With the exception of transportation necessary for Orientation and Mobility Training, Individual Transportation Services shall not be billed when provided during the same time period as Day Services.

Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. For an enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
- Payments that are passed through to users of supported employment programs; or
- Payments for vocational training that is not directly related to an enrollee's supported employment program.

Day Services are not intended to replace services available through the Medicaid State Plan/TennCare program.

Family Model Residential Support – Family Model Residential Support shall mean a type of residential service having individualized services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin. The service includes direct assistance as needed with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act. The caregivers shall be recruited, screened, trained prior to providing services, and supervised by the Family Model Residential Support provider agency. The Family Model Residential Support provider shall oversee the enrollee's health care needs.

With the exception of homes that were already providing services to 3 residents prior to January 1, 2004, a Family Model Residential Support home shall have no more than 2 residents who receive services and supports.

The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the enrollee is not receiving Day Services or is not at school or work. Therapeutic goals and objectives shall be required for enrollees receiving Family Model Residential Support.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare program, transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such. With the exception of Individual Transportation Services necessary for Orientation and Mobility Training or Behavioral Respite Services, an enrollee receiving Family Model Residential Support shall not be eligible to receive Individual Transportation Services.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to the enrollee's parent, step-parent, spouse, child, or sibling or to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

Family Model Residential Support may be provided out-of-state under the following circumstances:

- Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the enrollee's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)

- Out-of-state services shall be limited to a maximum of 14 days per enrollee per year.

- The waiver service provider agency must be able to assure the health and safety of the enrollee during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state.

- During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the enrollee and must ensure that staff meet waiver provider qualifications.

- The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other

expenses incurred by the enrollee while receiving out-of-state services shall be the responsibility of the enrollee and shall not be reimbursed through the waiver.

Medical Residential Services – Medical Residential Services shall mean a type of residential service provided in a residence where all residents require direct skilled nursing services and habilitative services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting. Medical Residential Services must be ordered by the enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services. The enrollee who receives Medical Residential Services shall require direct skilled nursing services on a daily basis and at a level that can not for practical purposes be provided through two or fewer daily skilled nursing visits.

The service includes direct assistance as needed with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

If an enrollee receiving Medical Residential Services owns or leases the place of residence, the enrollee (or the enrollee's parent, guardian, or conservator acting on behalf of the enrollee) shall have a voice in choosing other individuals with direct skilled nursing service needs who reside in the residence and the staff who provide services and supports. The enrollee shall have the right to manage personal funds as specified in the individual support plan.

The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports 24 hours per day when the enrollee is not receiving Day Services or is not at school or work. Therapeutic goals and objectives shall be required for enrollees receiving Medical Residential Services support.

Medical Residential Services are not intended to replace services available through the Medicaid State Plan/TennCare program.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare program, transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such. With the exception of Individual Transportation Services necessary for Orientation and Mobility Training or Behavioral Respite Services, an enrollee receiving Medical Residential Services shall not be eligible to receive Individual Transportation Services.

Reimbursement for Medical Residential Services shall not include the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the enrollee's immediate family or to the enrollee's conservator.

Reimbursement shall not be made for room and board if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the enrollee, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the enrollee and who provides services to the enrollee in the enrollee's place of residence. If an enrollee owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

Medical Residential Services may be provided out-of-state under the following circumstances:

- Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the enrollee's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)

- Out-of-state services shall be limited to a maximum of 14 days per enrollee per year.

- The waiver service provider agency must be able to assure the health and safety of the enrollee during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state.

- During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the enrollee and must ensure that staff meet waiver provider qualifications.

- The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the enrollee while receiving out-of-state services shall be the responsibility of the enrollee and shall not be reimbursed through the waiver.

Nutrition Services - Nutrition Services shall mean assessment of nutritional needs, nutritional counseling, and education of the enrollee and of caregivers responsible for food purchase, food preparation, or assisting the enrollee to eat. Nutrition Services must be provided in accordance with therapeutic goals and objectives specified in a plan of care developed by a dietitian or nutritionist. A dietitian or nutritionist who provides Nutrition Services must provide services

within the scope of licensure and must be licensed as required by the State of Tennessee. Nutrition Services are intended to promote healthy eating practices and to enable the enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.

Nutrition Services must be provided face to face with the enrollee or, for purposes of education, with the caregivers responsible for food purchase, food preparation, or assisting the enrollee to eat. Nutrition Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Speech, Language, and Hearing Services, Orientation and Mobility Training, or Behavior Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently.

Nutrition Services are not intended to replace services available through the Medicaid State Plan/TennCare program.

Nutrition Services shall be limited to a maximum of 1.5 hours per enrollee per day.

Orientation and Mobility Training – Orientation and Mobility Training shall mean assessment of the ability of an enrollee who is legally blind to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the enrollee and of caregivers responsible for assisting in the mobility of the enrollee.

Orientation and mobility training shall be based on a formal assessment of the enrollee and may include concept development (i.e. body image); motor development (i.e. motor skills needed for balance, posture and gait); sensory development (i.e. functioning of the various sensory systems); residual vision stimulation and training; techniques for travel (indoors and outdoors) including human guide technique, trailing, cane techniques, following directions, search techniques, utilizing landmarks, route planning, techniques for crossing streets, and use of public transportation; and instructional use of Low Vision devices.

Orientation and Mobility Training shall be provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). Orientation and Mobility Training shall be provided face to face with the enrollee or, for purposes of training and education, with the caregivers responsible for assisting in the mobility of the enrollee. Therapeutic goals and objectives shall be required for enrollees receiving Orientation and Mobility Training. Continuing approval of Orientation and Mobility Training shall require documentation of reassessment of the enrollee's condition and continuing progress of the enrollee toward meeting the goals and objectives.

An enrollee receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services. Orientation and Mobility Training shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Behavior Services, or Speech, Language, and Hearing Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently.

Orientation and Mobility Training shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

Orientation and Mobility Training shall be limited to a maximum of 60 hours of services per enrollee per year.

Personal Assistance – Personal Assistance shall mean the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act. Personal Assistance shall be provided in accordance with therapeutic goals and objectives as specified in the plan of care.

Personal Assistance may be provided in the home or community; however, it shall not be provided in school settings and shall not be provided to replace personal assistance services required to be covered by schools or services available through the Medicaid State Plan/TennCare program. Personal Assistance may be provided during the day or night, as specified in the plan of care. With the exception of Personal Assistance reimbursed on a per diem basis, Personal Assistance staff shall not be permitted to have sleep time when on duty. An enrollee who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance. Personal Assistance shall not be provided during the same time period when the enrollee is receiving Day Services. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the enrollee. The Personal Assistance provider shall not be the spouse and shall not be the enrollee's parent if the enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

An enrollee receiving Personal Assistance shall be eligible to receive Individual Transportation Services.

Personal Assistance may be provided out-of-state under the following circumstances:

- Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the enrollee's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)

- Out-of-state services shall be limited to a maximum of 14 days per enrollee per year.

- The waiver service provider agency must be able to assure the health and safety of the enrollee during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state.

- During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the enrollee and must ensure that staff meet waiver provider qualifications.

- The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the enrollee while receiving out-of-state services shall be the responsibility of the enrollee and shall not be reimbursed through the waiver.

Residential Habilitation – Residential Habilitation shall mean a type of residential service having individualized services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation household chores) essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act. The Residential Habilitation dwelling may be rented, leased, or owned by the Residential Habilitation provider and shall be licensed by the State of Tennessee. The Residential Habilitation provider shall provide personal funds management as specified in the plan of care. Therapeutic goals and objectives shall be required for enrollees receiving Residential Habilitation. The Residential Habilitation provider shall oversee the enrollee's health care needs.

A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.

The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the enrollee is not receiving Day Services or is not at school or work

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare program, transportation shall be a component of Residential Habilitation and shall be included in the reimbursement

rate for such. With the exception of Individual Transportation Services necessary for Orientation and Mobility Training or Behavioral Respite Services, an enrollee receiving Residential Habilitation shall not be eligible to receive Individual Transportation Services.

Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the enrollee's immediate family or to the enrollee's conservator.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

Residential Habilitation may be provided out-of-state under the following circumstances:

- Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the enrollee's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)
- Out-of-state services shall be limited to a maximum of 14 days per enrollee per year.

- The waiver service provider agency must be able to assure the health and safety of the enrollee during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state.

- During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the enrollee and must ensure that staff meet waiver provider qualifications.

- The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the enrollee while receiving out-of-state services shall be the responsibility of the enrollee and shall not be reimbursed through the waiver.

Supported Living – Supported Living shall mean a type of residential service having individualized services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside in a home that is under the control and responsibility of the enrollee. The service includes direct assistance as needed with activities of daily living (e.g., bathing, dressing, personal hygiene,

eating, meal preparation (excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act. The Supported Living provider shall not own the enrollee's place of residence or be a co-signer of a lease on the enrollee's place of residence unless the Supported Living provider signs a written agreement with the enrollee that states that the enrollee will not be required to move if the primary reason is because the enrollee desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to an enrollee if such entity requires, as a condition of renting or leasing, the enrollee to move if the Supported Living provider changes. The enrollee (or the enrollee's parent, guardian, or conservator acting on behalf of the enrollee) shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports. The enrollee shall have the right to manage personal funds as specified in the Individual Support Plan. The Supported Living home shall have no more than 3 residents including the enrollee. If two or more individuals share the home, each may select the Supported Living provider of their choice. Therapeutic goals and objectives shall be required for enrollees receiving Supported Living. The Supported Living provider shall oversee the enrollee's health care needs.

Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must have an operable smoke detector and a second means of egress.

The Supported Living provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the enrollee is not receiving Day Services or is not at school or work.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare program, transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such. With the exception of Individual Transportation Services necessary for Orientation and Mobility Training or Behavioral Respite Services, an enrollee receiving Supported Living shall not be eligible to receive Individual Transportation Services.

Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the enrollee and who provides services to the enrollee in the enrollee's home. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

Supported Living may be provided out-of-state under the following circumstances:

- Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the enrollee's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)

- Out-of-state services shall be limited to a maximum of 14 days per enrollee per year.

- The waiver service provider agency must be able to assure the health and safety of the enrollee during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state.

- During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the enrollee and must ensure that staff meet waiver provider qualifications.

- The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the enrollee while receiving out-of-state services shall be the responsibility of the enrollee and shall not be reimbursed through the waiver.

Vehicle Accessibility Modifications – Vehicle Accessibility Modifications shall mean interior or exterior physical modifications (1) to a vehicle owned by the enrollee or (2) to a vehicle which is owned by the guardian or conservator of the enrollee and which is routinely available for transport of the enrollee. Such modifications must be intended to ensure the transport of the enrollee in a safe manner. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded.

Vehicle Accessibility Modifications shall not replace Medicaid State Plan/TennCare Program services, and the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Vehicle Accessibility Modifications shall be limited to a maximum of $20,000 per enrollee per 5-year period.

Physical Therapy - Physical therapy shall mean diagnostic, therapeutic, and corrective services, which are within the scope of state licensure. Physical Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further

loss of function are also included within this definition. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist. Physical Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the enrollee. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).

Physical Therapy shall be provided in accordance with a treatment plan developed by a licensed physical therapist based on a comprehensive assessment of the enrollee's needs and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Physical Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Physical Therapy services shall require documentation of reassessment of the enrollee's condition and continuing progress of the enrollee toward meeting the goals and objectives.

Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language, and Hearing Services; Nutrition Services, Orientation and Mobility Training; or Behavior Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis. Physical Therapy is not intended to replace services that would normally be provided by direct care staff.

Physical Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.
Physical Therapy assessments shall be limited to a maximum of 3.0 hours per enrollee per day, and other Physical Therapy services shall be limited to a maximum of 1.5 hours per enrollee per day. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.

Occupational Therapy - Occupational Therapy shall mean diagnostic, therapeutic, and corrective services, which are within the scope of state licensure. Occupational Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist. Occupational Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the enrollee. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).

Occupational Therapy shall be provided in accordance with a treatment plan developed by a licensed occupational therapist based on a comprehensive assessment of the enrollee's needs and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Occupational Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Occupational Therapy services shall require documentation of reassessment of the enrollee's condition and continuing progress of the enrollee toward meeting the goals and objectives.

Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Hearing, and Language Services; Nutrition Services, Orientation and Mobility Training, or Behavior Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis. Occupational Therapy is not intended to replace services that would normally be provided by direct care staff.

Occupational Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.

Occupational Therapy assessments shall be limited to a maximum of 3.0 hours per enrollee per day, and other Occupational Therapy services shall be limited to a maximum of 1.5 hours per enrollee per day. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.

Speech, Language, and Hearing Services- Speech, Language, and Hearing Services shall mean diagnostic, therapeutic, and corrective services which are within the scope of state licensure which enable an enrollee to improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function. Services must be provided by a licensed speech language pathologist or by a licensed audiologist. Speech, Language, and Hearing Services must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the enrollee. Speech, Language, and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language, and Hearing assessments (i.e., assess and treat orders are not accepted).

Speech, Language, and Hearing Services shall be provided in accordance with a treatment plan developed by a licensed speech language pathologist or a licensed audiologist based on a comprehensive assessment of the enrollee's needs and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Speech, Language, and Hearing Services to prevent or minimize deterioration involving a

chronic condition which would result in further loss of function. Continuing approval of Speech, Language, and Hearing Services shall require documentation of reassessment of the enrollee's condition and continuing progress of the enrollee toward meeting the goals and objectives.

Speech, Language, and Hearing Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Training, or Behavior Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language, and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis. Speech, Language, and Hearing Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare program. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.

Speech, Language, and Hearing Services assessments shall be limited to a maximum of 3.0 hours per enrollee per day, and other Speech, Language, and Hearing Services shall be limited to a maximum of 1.5 hours per enrollee per day. Speech, Language, and Hearing Services assessments shall not be billed on the same day with other Speech, Language, and Hearing Services.

Nursing Services - Nursing Services shall mean skilled nursing services that fall within the scope of Tennessee's Nurse Practice Act and that are directly provided to the enrollee in accordance with a plan of care. Nursing Services shall be ordered by the enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services. Nursing Services shall be provided face to face with the enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition. Therapeutic goals and objectives shall be required for enrollees receiving Nursing Services.

This service shall be provided in home and community settings, as specified in the Plan of Care, excluding inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's). An enrollee who is receiving Medical Residential Services shall not be eligible to receive Nursing Services during the hours Medical Residential Services are being provided.

Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently.

Nursing Services are not intended to replace services available through the Medicaid State Plan/TennCare program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare

Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.

Dental Services

Adult Dental Services (Statewide Waiver) – Adult Dental Services shall mean accepted dental procedures which are provided to adult enrollees (i.e., age 21 years or older) as specified in the plan of care and for which there is no coverage for adults through the Medicaid State Plan/TennCare program. Adult Dental Services may include fillings, root canals, extractions, the provision of dentures, and other dental treatments to relieve pain and infection. Anesthesia services provided in the dentist's office and billed by the dentist shall be included within the definition of Adult Dental Services. Adult Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting. Adult Dental Services shall exclude orthodontic services.

Adult Dental Services shall be limited to adults age 21 years or older who are enrolled in the waiver. Adult Dental Services are not intended to replace services available through the Medicaid State Plan/TennCare program. All Dental Services for children enrolled in the waiver are provided through the TennCare EPSDT program.

Dental Services (Arlington Waiver)- Dental Services shall mean accepted dental procedures which are provided to adult enrollees (i.e., age 21 years or older) as specified in the plan of care and for which there is no coverage for adults through the Medicaid State Plan/TennCare program. Dental Services may include preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments to relieve pain and infection. Anesthesia services provided in the dentist's office and billed by the dentist shall be included within the definition of Dental Services. Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting. Dental Services shall exclude orthodontic services.

Dental Services shall be limited to adults age 21 years or older who are enrolled in the waiver. Dental Services are not intended to replace services available through the Medicaid State Plan/TennCare program. All Dental Services for children enrolled in the waiver are provided through the TennCare EPSDT program.

Vision Services –(Arlington Waiver) Vision Services shall mean routine eye examinations and refraction; standard or special frames for eyeglasses; standard, bifocal, multifocal, or special lenses for eyeglasses; contact lenses; and dispensing fees for ophthalmologists, optometrists, and opticians.

Vision Services are not intended to replace services available through the Medicaid State Plan/TennCare program. All Vision Services for children enrolled in the waiver are provided through the TennCare EPSDT program.

Attachment 3

Level Descriptions for Residential Habilitation, Supported Living

Level One
Level One rates are to serve an individual who requires only a little staff support to perform the activities of daily living and needs only routine supervision to remain safe and healthy. The individual may need reminders to perform some self-care or other activities of daily living and may require some or complete assistance to complete activities such as money management, making health care arrangements or other activities requiring complex skills. The individual does not have behavioral or medical problems that are significant enough to routinely restrict participation in day services or community activities.

Rate designations for Level One made by providers will be compared to ICAP results as follows:

Service Level Profile Score: 7-9
Maladaptive Behavior Index Profile: Normal to Moderately Serious
Health: No limitation in daily activities or Few or slight limitations in daily activities.

Level Two
Level Two rates are to serve an individual who requires a moderate amount of staff support to perform activities of daily living and needs close supervision to remain safe and healthy. The person may need assistance as well as reminders to perform some or all self-care tasks and other activities of daily living and requires complete assistance with all activities requiring complex skills. The individual does not have behavioral or medical problems that are significant enough to routinely restrict participation in day services or community activities. The person does not routinely require awake overnight staff.

Rate designations for Level Two made by providers will be compared to ICAP results as follows:

Service Level Profile Score: 4-6
Maladaptive Behavior Index Profile: Normal to Moderately Serious
Health: No limitation in daily activities or Few or slight limitations in daily activities.

Level Three
Level Three rates are to serve an individual who requires staff assistance with most or all activities of daily living including basic self care tasks such as eating, dressing, bathing and toileting as well as more complex activities of daily living. The person requires continuous staff supervision including awake overnight staff in order to remain safe and healthy.

Rate designations for Level Three made by providers will be compared to ICAP results as follows:

Service Level Profile Score: 1-3
Maladaptive Behavior Index Profile: Normal to Moderately Serious
Health: No limitation in daily activities or Few or slight limitations in daily activities.

Level Four
Level Four rates are to serve an individual who has behavioral problems that are so significant that the person requires extremely close, continuous supervision and requiring 2 staff with them at least during some times each day and including awake overnight staff so that he is not a danger to himself or someone else or so that he does not destroy costly property.

Level Four rates are also to serve an individual who requires staff assistance with all activities of daily living including basic self care and requires intensive staff support for integration of multiple health and safety strategies throughout the day including specialized positioning, specialized mealtime assistance techniques and transfers requiring more than one person to assist.

Individuals in Level Four require health care oversight by a Registered Nurse.

Rate designations for Level Four made by providers will be compared to ICAP results as follows:

Service Level Profile Score: 1-9
Maladaptive Behavior Index Profile: Serious to Very Serious General Behavior
Health: No limitation in daily activities or Few or slight limitations in daily activities.
Or
Service Level Profile 1-2
Maladaptive Behavior: Normal to Very Serious
Health: No limitation in daily activities of Few of slight limitations in daily activities or Many or significant limitations in daily activities
Required Care by Nurse of Physician: Less than monthly, Monthly, Weekly or Daily (if not to criteria for Medical Residential Services.)
Mobility: Does not walk, Limited to bed most of the day, Confined to bed for entire day.
Mobility Assistance Needed: Always needs help of another person.

Medical Residential Services (Level 5)
Medical Residential rates are to serve individuals living alone or in a home shared by individuals who have similar needs. They are individuals who have medical problems sufficient to have a physician's order that requires direct skilled nursing on a daily basis and at a level that cannot for practical purposes be provided through two or fewer visits by a licensed nurse. The individuals require health care oversight provided by a Registered Nurse. Each person may need limited to complete support to perform activities of daily living.
Rate designations for Medical Residential made by providers will be compared to ICAP results as follows:

Service Level Profile Score: 1-9
Maladaptive Behavior Index Profile: Normal to Moderately Serious
Health: Many or significant limitations in daily activities
PSR Score: Levels 5 or 6
Required Care by Nurse of Physician: Daily (check to be sure needs more than twice daily) or 24-hour immediate access

Level 6
Level Six rates are to serve an individual who has behavioral problems that are so significant that the person requires extremely close, continuous supervision requiring 2 staff at all times during the day and including awake overnight staff so that he is not a danger to himself or someone else. Level 6 rates may also be used for individuals who require that level of staffing for preventive purposes for an individual with a low frequency behavior that was life threatening to others in the past (e.g. murder, pedophilia).

Rate designation for Level 6 rates will be compared to ICAP results as follows:

Service Level Profile 1-9
Maladaptive Behavior Index Profile: Very Serious (or past history of unpredictable and extremely dangerous behavior)
Health: No limitations to Many or significant limitations in daily activities

Special Adjustment
A special adjustment is available for Levels 1-3 for homes with 4 or fewer people. The adjustment does not change the rate Level designated for the individual, but adjusts the rate Level to meet one or more of the following circumstances.

1. The individual has a history of significant behavioral or psychiatric problems that are now not apparent due to the design or intensity of services being received and the rate level does not cover the cost of such services. Less intensive services will likely result in recurrence of previous problems. The Regional Office must review the special adjustment at least annually.

2. The individual is in circumstances that are time limited but that require support(s) at a higher level than described by the Level and the rate level does not cover the cost of such services. (For example, the person has had a serious illness, injury, or surgery that requires more support while he is recovering than the Level describes.) A special adjustment may be approved for up to 90 days and may be extended for an additional 90 days.
3. The person needs a roommate and requires a special adjustment until one moves in. A special adjustment may be approved for up to 90 days and may be extended for an additional 90 days.

Levels Descriptions For Day Services

Facility Based Levels

Level One

Level One rates are to serve an individual who requires only a little staff support to perform the activities of daily living and needs only routine supervision to remain safe and healthy and participate in facility based habilitative activities. The individual may need reminders to perform some self-care or other activities of daily living and may require some or complete assistance to complete activities requiring complex skills. The individual does not have behavioral or medical problems that are significant enough to routinely restrict participation in facility based day services.

Rate designations for Level One made by providers will be compared to ICAP results as follows:

Service Level Profile Score: 7-9
Maladaptive Behavior Index Profile: Normal to Moderately Serious
Health: No limitation in daily activities or Few or slight limitations in daily activities.

Level Two

Level Two rates are to serve an individual who requires a moderate amount of staff support to perform activities of daily living and needs close supervision to remain safe and healthy and to participate in facility based habilitative activities . The person may need assistance as well as reminders to perform some or all self-care tasks and other activities of daily living and requires complete assistance with all activities requiring complex skills. The individual does not have behavioral or medical problems that are significant enough to routinely restrict participation in facility based day services.

Rate designations for Level Two made by providers will be compared to ICAP results as follows:

Service Level Profile Score: 4-6
Maladaptive Behavior Index Profile: Normal to Moderately Serious
Health: No limitation in daily activities or Few or slight limitations in daily activities.

Level Three

Level Three rates are to serve an individual who requires staff assistance with most or all activities of daily living including basic self care tasks such as eating, dressing, bathing and toileting as well as more complex activities of daily living. The person requires continuous staff supervision in order to remain safe and healthy and to participate in facility based habilitative activities. The individual does not have behavioral or medical problems that are significant enough to routinely restrict participation in facility based day services.

Rate designations for Level Three made by providers will be compared to ICAP results as follows:

Service Level Profile Score: 1-3
Maladaptive Behavior Index Profile: Normal to Moderately Serious

Health: No limitation in daily activities or Few or slight limitations in daily activities.

Special Needs (Level Four)
Level Four rates are to serve an individual who has behavioral problems that are so significant that the person requires extremely close, continuous supervision so that he is not a danger to himself or someone else or so that he does not destroy costly property and to be able to participate in facility based habilitative activities.

Level Four rates are also to serve an individual who requires staff assistance with all activities of daily living including basic self care and requires intensive staff support for integration of multiple health and safety strategies throughout the day including specialized positioning, specialized mealtime assistance techniques and transfers requiring more than one person to assist. Individuals require staff assistance to participate in some or all facility based habilitative activities.

Rate designations for Level Four made by providers will be compared to ICAP results as follows:

Service Level Profile Score: 1-9
Maladaptive Behavior Index Profile: Serious to Very Serious General and Very Serious in Internalized and/or Externalized
Health: No limitation in daily activities or Few or slight limitations in daily activities.
Or
Service Level Profile 1-2
Maladaptive Behavior: Normal to Very Serious
Health: No limitation in daily activities or Few or slight limitations in daily activities or Many or significant limitations in daily activities
Required Care by Nurse of Physician: Less than monthly, Monthly, Weekly or Daily (if not to criteria for Medical Residential Services.)
Mobility: Does not walk, or Limited to bed most of the day, or Confined to bed for entire day.
Mobility Assistance Needed: Always needs help of another person.

Level 6
Level Six rates are to serve an individual who has behavioral problems that are so significant that the person requires extremely close, continuous supervision requiring 2 staff at all times during the day and including awake overnight staff so that he is not a danger to himself or someone else. Level 6 rates may also be used for individuals who require that level of staffing for preventive purposes for an individual with a low frequency behavior that was life threatening to others in the past (e.g. murder, pedophilia).

Rate designation for Level 6 rates will be compared to ICAP results as follows:

Service Level Profile 1-9
Maladaptive Behavior Index Profile: Very Serious (or past history of unpredictable and extremely dangerous behavior)
Health: No limitations to Many or significant limitations in daily activities.

Community Based Levels:

Community Based Rate
The Community based rate is to serve all individual except those with Special Needs.

Special Needs (Level Four)
Level Four rates are to serve an individual who has behavioral problems that are so significant that the person requires extremely close, continuous supervision so that he is not a danger to himself or someone else or so that he does not destroy costly property and to be able to participate in community based habilitative activities.

Level Four rates are also to serve an individual who requires staff assistance with all activities of daily living including basic self care and requires intensive staff support for integration of multiple health and safety strategies throughout the day including specialized positioning, specialized mealtime assistance techniques and transfers requiring more than one person to assist. Individuals require staff assistance to participate in some or all community based habilitative activities.

Rate designations for Level Four made by providers will be compared to ICAP results as follows:

Service Level Profile Score: 1-9
Maladaptive Behavior Index Profile: Serious to Very Serious General and Very Serious in Internalized and/or Externalized
Health: No limitation in daily activities or Few or slight limitations in daily activities.
Or
Service Level Profile 1-2
Maladaptive Behavior: Normal to Very Serious
Health: No limitation in daily activities or Few or slight limitations in daily activities or Many or significant limitations in daily activities
Required Care by Nurse of Physician: Less than monthly, Monthly, Weekly or Daily (if not to criteria for Medical Residential Services.)
Mobility: Does not walk, or Limited to bed most of the day, or Confined to bed for entire day.
Mobility Assistance Needed: Always needs help of another person.

Level 6

Level Six rates are to serve an individual who has behavioral problems that are so significant that the person requires extremely close, continuous supervision requiring 2 staff at all times during the day and including awake overnight staff so that he is not a danger to himself or someone else. Level 6 rates may also be used for individuals who require that level of staffing for preventive purposes for an individual with a low frequency behavior that was life threatening to others in the past (e.g. murder, pedophilia).

Rate designation for Level 6 rates will be compared to ICAP results as follows:

Service Level Profile 1-9
Maladaptive Behavior Index Profile: Very Serious (or past history of unpredictable and extremely dangerous behavior)

Health: No limitations to Many or significant limitations in daily activities

Employment Levels:

Follow Along
For individuals who are successfully employed in community jobs for two or more hours per day and require only occasional contacts with the employment staff in order to remain employed.

Group Model Employment
For individuals who are employed in community jobs for two or more hours per day as part of a group of four to eight individuals who function as a work team.

Employment
For individuals who are in employed in community jobs for two or more hours per day and require various amounts of assistance to remain employed.

Special Needs:
Special Needs/ Level Four rate is to serve an individual who is employed two or more hours per day and has behavioral problems that are so significant that the person requires extremely close, continuous supervision so that he is not a danger to himself or someone else or so that he does not destroy costly property and so that he can be successfully employed.

This rate is also to serve an individual who is employed two or more hours per day and, in order to be successfully employed requires staff assistance with all activities of daily living including basic self care and requires intensive staff support for integration of multiple health and safety strategies throughout the day including specialized positioning, specialized mealtime assistance techniques and transfers requiring more than one person to assist.

Rate designations for Level Four made by providers will be compared to ICAP results as follows:

Service Level Profile Score: 1-9
Maladaptive Behavior Index Profile: Serious to Very Serious General and Very Serious in Internalized and/or Externalized
Health: No limitation in daily activities or Few or slight limitations in daily activities.
Or
Service Level Profile 1-2
Maladaptive Behavior: Normal to Very Serious
Health: No limitation in daily activities or Few or slight limitations in daily activities or Many or significant limitations in daily activities
Required Care by Nurse of Physician: Less than monthly, Monthly, Weekly or Daily (if not to criteria for Medical Residential Services.)
Mobility: Does not walk, or Limited to bed most of the day, or Confined to bed for entire day.
Mobility Assistance Needed: Always needs help of another person.

Level 6

Level Six rates are to serve an individual who has behavioral problems that are so significant that the person requires extremely close, continuous supervision requiring 2 staff at all times during the day and including awake overnight staff so that he is not a danger to himself or someone else. Level 6 rates may also be used for individuals who require that level of staffing for preventive purposes for an individual with a low frequency behavior that was life threatening to others in the past (e.g. murder, pedophilia).

Rate designation for Level 6 rates will be compared to ICAP results as follows:

Service Level Profile 1-9
Maladaptive Behavior Index Profile: Very Serious (or past history of unpredictable and extremely dangerous behavior)
Health: No limitations to Many or significant limitations in daily activities

Level Descriptions for Family Model Residential Services

Category	Tier 1	Tier 2	Tier 3	Tier 4
Medical Status	Has few or no medical problems (ex. Seizures are fully controlled) Has medical problems but are self-managed (ex. Person with diabetes manages diet and injects self) Requires routine medical visits	Requires routine medical visits with sporadic follow-up of specialist if found during a routine visit. (ex. Person needs to see dermatologist due to an unknown rash)	Requires routine medical visits with ongoing specialist follow-ups. (10-20 times per year) (Ex. Routine blood work, frequent doctor/specialists appointments) Has some medical problems (ex. Seizures are only partially controlled with medication)	Requires medical oversight (ex. Special diets, education on medical diagnosis to note signs and symptoms) Requires medical visits with doctor/specialists (20-30 times per year)
Behavioral/ Mental Health Supports	Behaviors can be redirected by intervention from foster care provider (ex. Non-compliance with required chores)	Behavior guidelines must be followed to re-direct behavior. Infrequent behavior problems (ex. Physical aggression twice per year)	Formal behavior plan that may be used to re-direct.	Formal behavior plan with structured interventions or cyclic behavior patterns. Requires detailed data collection.

Category	Level A	Level B	Level C	Level D	Level E
Assistance Needed	Verbal assistance may be needed in some complex skills	Requires minimal hands-on assistance for some skills.	Requires hands-on assistance to complete most areas of self-help skills	Requires partial to complete assistance in all areas of self-help, decision making and complex skills	Requires st areas of sel making and
Specialized Training	None	None	Foster care provider may require training on simple, routine procedures such as special diets, taking of blood pressures, oxygen usage.	May require training on one or two complex procedures such as dysphagia, meal time challenges, behavior supports, range of motion for therapy plans	Requires tr complex pr positioning, mealtime cl site care, ex intermittent terminal ill
Supplemental Staff and Supervision	May be alone for short periods of time	May be alone for short periods but has access to family based provider when needed	Requires 24-hour supervision but sleeps through the night. Can share support staff with other family members (ex. Family-based provider can attend to other family members and still attend to the needs of the individual when they need them.)	Requires 1:1 sometimes, i.e. meals, bathing, dressing and needs additional staff up to 10 hours a week in addition to family based provider.	Requires 1: all awake h during the r individual i needs addit more hours addition to provider.
Supplemental Staff and Supervision	May be alone for short periods of time	May be alone for short periods but has access to family based provider when needed	Requires 24-hour supervision but sleeps through the night. Can share support staff with other family members (ex. Family-based provider can attend to other family members and still attend to the needs of the individual when they need them.)	Requires 1:1 sometimes, i.e. meals, bathing, dressing and needs additional staff up to 10 hours a week in addition to family based provider.	Requires 1: all awake h during the r individual i needs addit more hours addition to provider.

Note:

1) These guidelines should be used to determine at which overall level the person's needs are best described taking into consideration the combination of all categories.
2) If supplemental staff is needed in addition to the family-based provider see if level F or G description under supplemental staff is appropriate.
3) Documentation from therapists or other professionals is required to substantiate the stated needs .
4) These guidelines are for new rate requests for FB only.

Level Descriptions for Semi-Independent Living Services

Level	A	B	C	D	E
Unit	Month	Month	Month	Month	
Maximum Units	12	12	12	12	
Criteria	1-50 hours per month	51-75 hours per month	76-100 hours per month	101-150 hours per month	151-200 hour month

Level Descriptions for Respite Services

Level A – daily rate

It is the rate for individual provider or respite in a family model residential home.

Level B – daily rate

This rate is for individuals who do not require awake staff during the night. Rate is for 24 hour period.

Level C – daily rate

This rate is for individuals who require awake overnight staff. Rate is for 24 hour period.

Level D – hourly rate

The hourly respite rate is for individuals receiving a maximum of 8 hours of respite per day. If more than 8 hours per day are provided, the appropriate daily rate must be used.

Behavioral Respite Services
Daily rate only for individuals requiring intensive behavioral need.

Attachment 4

Staffing Standards for Residential and Day Services

Residential Services

The provider must develop a staffing plan and schedule for each residential habilitation home, supported living home and each home with medical residential services. The staffing plan must comply with any licensing requirements and be adequate to protect the individual's health and safety and carry out all activities required to meet the outcomes and goals identified in the Individual Support Plan. The plan must address staff coverage for peak hours, overnight hours and emergency and back up staffing.

The following additional requirements must be met:

For individuals who require low or moderate levels of staff support and supervision, at least one staff person must be on site whenever an individual is present in the home unless the individual present has a support plan permitting less than 24 hour supervision. In addition, where applicable all requirements for his safety in the absence of a staff person are met.

For individuals who require high levels of staff support and supervision, at least one staff person must be on site whenever an individual is present in the home.

For individuals funded at Level 4, RN oversight of health care is required.

For individuals who are receiving Medical Residential Services, an LPN at least must be on site whenever an individual is present in the home.

The provider's staffing plan for the home must be present in the home and adherence to the plan will be monitored by reviewing time sheets.

Day Services

The provider must develop a staffing plan for each day service provided. The staffing plan must comply with any licensing requirements and be adequate to protect the individual's health and safety and carry out all activities required to meet the outcomes and goals identified in the Individual Support Plan.

Natural supports on the job or in community activities may be used in the provider's staffing plan for employment or community based day services and but does not reduce the provider's responsibility for the day service and does not affect billing for the day service.

At no time may an individual be left unattended in a vehicle.

The provider's staffing plan for the day service must be present in the provider's administrative office and adherence to the plan must be documented for purposes of monitoring.

Attachment 6

DESCRIPTION OF THE WAIVER PROGRAM

A. Background/Purpose

The Self-Determination Waiver Program will serve Tennessee citizens with mental retardation who have moderate service needs that can be satisfactorily met with a cost-effective array of home and community services that complement other supports available to them in their homes and the community. The Self-Determination Waiver affords participants the opportunity – based on individual preference and the willingness to assume the responsibilities that accompany self-determination – to lead the person-centered planning process and directly manage services, including the recruitment and management of service providers. Participants and families (as appropriate) who elect self-determination will be empowered and have the responsibility for managing a self-determination budget that affords flexibility in service design and delivery. During the development of the Individual Support Plan (ISP)/plan of care, individuals and families will receive an orientation to self-determination, including information concerning the added responsibilities and benefits of self-determination. When self-determination is selected, the ISP/plan of care will detail the services that will be participant-managed and the participant's responsibilities. Participants and families who prefer may elect to receive some or all of their services through the standard service delivery method through which an enrolled service provider chosen by the individual hires and manages the staff, delivers the service in accordance with the ISP and is paid directly by the state.

The target population for the Self-Determination Waiver Program consists of children and adults with mental retardation who meet ICF/MR level of care criteria and who are on the DMRS waiting list for home and community-based services. Under the terms of the *Brown vs. Tennessee Department of Finance & Administration* lawsuit settlement agreement, Tennessee is embarking on a major initiative to reduce waiting lists for home and community-based services. The Self-Determination Waiver Program is a critical element in this initiative. This waiver will not affect individuals who are served through Tennessee's existing HCBS waiver programs for persons with mental retardation (CMS waiver control #0128.90.R1 and #0357). Individuals will be assessed to determine whether the services available through the Self-Determination Waiver Program will meet their needs in a manner that assures their health and welfare. In the event that a person's health and welfare cannot be assured, the individual will be referred for possible enrollment in the existing HCBS waiver program or for alternative services.

When there is a change in the needs or life circumstances of a Self-Determination Waiver participant such that the program can no longer meet the individual's needs, there are procedures to transition the individual to the existing HCBS waiver program for persons with mental retardation, and, if not eligible for that program, to alternative services.

The Self-Determination Waiver Program will serve persons who have an established non-institutional place of residence where they live with their family, a non-related caregiver or in their own home and whose needs can be met effectively by the combination of services available through this waiver program and natural and other supports available to them. The Self-Determination Waiver Program does not

include licensed residential services or services in supported living arrangements provided through the existing HCBS waiver programs.

The Administrative Lead Agency (Division of Mental Retardation Services (DMRS), Department of Finance and Administration) will conduct necessary case management activities for the Self-Determination Waiver Program, DMRS eligibility determination, the intake, assessment, and enrollment process, developing the Individual Support Plan (ISP)/plan of care, ongoing monitoring of service provision and participant health and welfare, monitoring expenditures, responding to changes in the participant's condition or life circumstances, and addressing crises/emergencies as necessary. The performance of the Administrative Lead Agency will be monitored and overseen by the Bureau of TennCare, the state Medicaid agency.

The Self-Determination Waiver Program emphasizes individual and family control over choice of services. Individuals and families will be encouraged – but not required – to select self-determination. When self-determination is selected, individuals and families will be able to:

- Lead the service planning process;
- Recruit, hire, train, supervise, schedule and evaluate, and discharge individual personal assistance workers;
- Negotiate the rate of pay and other benefits of these workers;
- Recruit a provider for respite services;
- Recruit providers and direct payment for certain other waiver services;
- Engage a Financial Administration entity to pay the participant's worker(s); handle federal/state taxes and other payroll or benefits related to the employment of the worker(s); reimburse other service providers under the direction of the participant; and, track the participant's expenses and self-determination budget;
- Obtain the services of a supports broker to help manage the individual budget, recruit workers, discharge other participant service management responsibilities and provide additional assistance as directed by the individual or family;
- Have the flexibility to substitute among the services included in the self-determination budget so long as such changes are consistent with the ISP/plan of care; and,
- Designate a portion of the self-determination budget to purchase participant-designated goods and services.

When the individual or family does not elect self-determination, services will be furnished through the standard service delivery method.

Under the Self-Determination Waiver Program, each participant will have an individual budget. The amount of the budget will be determined based on an assessment of each person's need for the services available in the program. These services are classified under two broad service categories:

- **Supports for Community Living**. This category includes the following services: Personal Assistance, Respite, Behavioral Respite Services, Day Services, Individual Transportation Services, Supports Brokerage, Financial Administration, and Participant-Designated Goods and Services. Financial Administration and Participant-Designated Goods and Services will be available only to participants who elected self-determination. A participant's use of any service or combination of services included in the Supports for Community Living Category is limited to $23,000 per year per participant, unless an exception is approved.

- **Professional and Technical Support Services.** This category includes the following services: Physical Therapy, Occupational Therapy; Speech, Language and Hearing Services; Nutrition Services; Nursing Services; Behavior Services; Environmental Accessibility Modifications; Vehicle Accessibility Modifications; Personal Emergency Response Systems; Specialized Medical Equipment and Supplies and Assistive Technology; Orientation and Mobility Training; and Adult Dental Services. A participant's use of any service or combination of services included in the Professional and Technical Support Services Category is limited to $7,000 per year per participant, unless an exception is approved.

In the event that an exception to the broad service category limit is approved, the combination of service components included in the Supports for Community Living Category and the Professional and Technical Support Service Category may not exceed $30,000 per participant per year. The amount of the participant's initial individual budget may be increased to address newly identified needs or changes in the participant's life circumstances, provided that the combination of service components does not exceed $30,000.

When the person's individual budget reaches $30,000, emergency assistance services as specified in Appendix B may be provided to the person in an amount up to $6,000 in order to provide an extra measure of protection when the person experiences a crisis or emergency situation that threatens his/her health and well-being. The total budget for all waiver services, including emergency assistance services, shall not exceed $36,000 per year per participant. Emergency assistance services consist of services that are available under the Supports for Community Living Category and/or the Professional and Technical Support Service Category.

B. Administration:

The Self-Determination Waiver Program will be administered by the Division of Mental Retardation Services (DMRS), Tennessee Department of Finance and Administration. The state Medicaid agency – the Bureau of TennCare – will oversee the operation of the program. DMRS regional offices will serve as the local point of entry for this waiver. These offices will conduct intake, assessment, enrollment, case management and arrange for emergency backup services as necessary.

C. Eligibility:

Participation in the Self-Determination Waiver Program is limited to individuals who:

- Do not require residential waiver services (e.g., residential habilitation, supported living) and have an established non-institutional place of residence where they live with their family, a non-related caregiver or in their own home;
- Are on the DMRS waiting list for services and classified as in the crisis, urgent, or active waiting list categories. Enrollment in the program is prioritized and offered first to persons in the crisis wait list category, then to individuals in the urgent category, and then to persons in the active category up to the number of persons authorized to be served in the program each year, using the identification process established by DMRS;
- Meet ICF/MR level of care criteria, as verified by approval of the Preadmission Evaluation (PAE) for ICF/MR Care;
- Are eligible for Medicaid;
- Have been assessed and found to:
  - Have mental retardation manifested before eighteen (18) years of age; or,

- Have a developmental disability, which is defined as a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in mental retardation and be a child four (4) years of age or younger; and,

- Have been assessed as having needs that can be satisfactorily met by the services available through the Self-Determination Waiver Program in a manner that assures the individual's health and welfare.

D. Service Network

Self-Determination Waiver Program participants will have access to services through the current provider network as well as being able to recruit additional providers when self-determination is selected.

E. Participant-Managed Service Delivery Method

The Self-Determination Waiver Program provides that certain services that may be managed directly by the participant. The participant or the conservator or family (as appropriate) will decide whether to directly manage these services or receive them through the standard service delivery method. When a participant or the conservator or family elects to manage one of more services included in the ISP/plan of care, a Financial Administration entity must be selected to facilitate participant management. The participant or the conservator or family may also elect to engage a supports broker to assist in their management of the self-determination budget and other facets of self-determination. Supports brokerage services also may be used when the participant elects not to manage services directly but wants the other forms of assistance that a supports broker may provide.

The participant's self-determination budget will include the services in the ISP/plan of care that the participant has elected to manage directly. The self-determination budget will be managed by the participant with the assistance of a supports broker if the participant chooses. The participant will have the flexibility in managing the self-determination budget .

1. Participant Role Under Self-Determination:

In the case of minor children, the decision to select self-determination will be made by the child's legally responsible family member or guardian. In the case of adults, the decision to select self-determination will be made by the participant except when the participant has a legally-appointed representative. In addition, an adult participant who does not have a legally-appointed representative may designate one or more individuals (including family members, friends, or other persons) to advise and assist the participant in self-determination. Such a representative must meet the following requirements:

- Demonstrate knowledge and understanding of the participant's needs and preferences;
- Be willing to comply with program requirements;
- Be at least 18 years of age;
- Be approved by the participant to act in this capacity; and,
- Not be a provider of services under this program.

When a representative has been designated, the representative will act on the participant's behalf in conducting activities related to self-determination and participant service management.

The participant's key responsibilities when self-determination is selected are:

- Lead the ISP development process;
- Receive an orientation to and training in self-determination from a supports broker;
- Understand the rights and responsibilities of directing one's care and be willing to manage services or select a representative who is willing and capable of assuming this responsibility;
- Select a Financial Administration entity;
- Select a supports broker, if desired;
- Develop a back-up/emergency plan that is included in the ISP;
- Recruit, hire, and manage personal assistants and other providers of participant-managed services;
- Prepare an outline of duties and work schedule for providers of participant-managed services;
- Notify providers of participant-managed services of schedule changes in a timely manner;
- Train and evaluate providers of participant-managed services as necessary;
- Negotiate reimbursement or payment rates with providers of participant-managed services;
- Serve as the employer of record for providers of participant-managed services;
- Verify accuracy of documentation or provide documentation, as appropriate, to Financial Administration entity regarding services provided;
- Review and monitor payments for services reported by the Financial Administration entity to confirm that services have been rendered;
- Notify the case manager and supports broker (if applicable) of concerns about service delivery that affect health and welfare; and
- Develop and manage services within the self-determination budget

2. **Supports Broker Role**

Supports brokerage facilitates self-determination and participant-managed service delivery; authority and responsibility for self-determination remain with the individual and family. When a participant who has elected self-determination opts to use a supports broker, the supports broker will have the following responsibilities as authorized by the participant:

- Provide training to the participant concerning self-determination;
- Assist the participant in the recruitment of providers of participant-managed services;
- Assist the participant in the scheduling, training and supervision of providers of participant-managed services;
- Assist the participant in managing and monitoring the self-determination budget;
- Assist the participant in monitoring and evaluating the performance of providers of participant-managed services;
- Maintain contact with the participant to ensure that needed services are being provided; and,
- Participate in the development of the ISP/plan of care if requested by participant;

In addition, the supports broker has an affirmative responsibility to notify the participant's case manager in the event of concerns about service delivery problems or issues that affect health and welfare.

3. **Case Manager Role in Self-Determination**

All participants will have an assigned Administrative Lead Agency case manager. The case manager will have the following responsibilities:

- Develop the initial, interim plan of care;
- Facilitate the development of the participant's ISP/plan of care, including arranging for a person-centered planning facilitator if desired by the participant;
- To ensure that services are initiated within required time frames;
- Provide an orientation to self-determination so that the participant has the information necessary to understand the requirements and responsibilities associated with self-determination;
- Inform participants who elect self-determination of available Financial Administration entities and supports brokers;
- Continuously review the status of the participant's self-determination budget;
- Conduct ongoing monitoring of the implementation of the ISP/plan of care and participant health and welfare; and,
- Authorize alternative emergency back-up services as necessary in the event that the emergency back-up services provided for in the ISP/plan of care cannot be employed.

4. **Financial Administration (FA) Role:**

A participant must utilize a Financial Administration (FA) entity when self-determination is selected. The FA entity will administer the financial, ministerial and clerical aspects associated with hiring or employment of individuals by the participant or the participant's guardian/conservator and make payment for participant-managed services. The FA entity bills for participant-managed services authorized in the ISP/plan of care and approved by the participant and pays the amounts due. The FA entity:

- Provides the individual or the individual's guardian/conservator with the information and materials required for them to carry out self-determination and participant service management, including procedures for approving payment for services and obtaining necessary payroll and employment information;
- Files claims with DMRS for payment through the MMIS;
- Reimburses providers of participant-managed services;
- Assures that funds are disbursed only for services that are authorized in the ISP, approved by the participant, and properly documented.
- Prepares and transmits a monthly, self-determination budget status report to the participant, the supports broker (if applicable) and the DMRS regional office case manager;
- Makes payroll deductions; and,
- Verifies that providers of participant-managed services possess the required qualifications and, as necessary, arranges for the criminal background checks at no cost to the participant.

5. **Use of Funds**

Disbursements for services managed by the participant or guardian/conservator through the self-determination budget will be made by the Financial Administration entity. Payment for participant-managed services shall require documentation such as a time sheet or invoice and must be approved by the participant prior to FA entity disbursement of funds. The participant may substitute among services specified in the approved ISP so long as the changes address support needs identified in the ISP and the amount of the self-determination budget is unaffected. The participant must notify the FA entity and supports broker (if applicable) of substitutions. Within the amount of the self-determination budget, participants also will be able to budget for Participant-Directed Goods and Services that address support needs identified in the ISP/plan of care.

6. **Termination of Self-Determination**

In the case of individuals who have elected self-determination but continue to be eligible for the Self-Determination Waiver Program, self-determination as the method of service provision will be terminated under the following circumstances:

- The participant voluntarily elects instead to employ the standard service delivery method;
- The participant does not carry out his/her responsibilities under self-determination; or,
- Continued use of self-determination as a method of service delivery poses a health and welfare risk.

In the event that a recommendation is made to terminate the self-determination option, the person's ISP will be revised. Termination of the use of the self-determined method will not affect the participant's ongoing receipt of services specified in the ISP. Services, however, will be provided through the standard method of service delivery.

F. Termination from the Self-Determination Waiver Program

An individual shall be terminated from the Self-Determination Waiver Program under the following circumstances:

- The person voluntarily terminates participation;
- The person moves out of the state of Tennessee;
- The person becomes ineligible for Medicaid or is found to be erroneously enrolled in the waiver program;
- The person no longer requires ICF/MR level of care;
- The person or the person's guardian or conservator refuses to abide by the ISP or related waiver policies, resulting in the inability to assure quality care or the health and safety of the person;
- The person's caregiver refuses to abide by the ISP or related waiver policies, resulting in the inability to assure quality care or the health and safety of the person, and alternate caregivers can not be found;
- The person is deceased; or,
- There is a change in the individual's needs or circumstances that results in the person's needs no longer being able to be met by the services offered under the Self-Determination Waiver Program and, as a consequence, the person's health and welfare can no longer be assured.

IV. Self-Direction Provisions:

A. Supports Brokerage Activities:

1) **Activities to be Performed:** Assist the participant in the management of participant-managed services, including providing training and information to the participant/representative concerning participant responsibilities in self-determination, and conducting other activities on behalf of the participant in accordance with the scope of supports brokerage services.

2) **Specific Responsibilities:** The supports broker is a facilitator/personal agent on behalf of the participant. The supports broker provides information and education to the participant concerning service management responsibilities, including employing and supervising individual workers. Supports brokerage does not include activities normally conducted by the person's case manager.

Who Will Provide Oversight/Monitoring? DMRS regional office case manager.

Method and Frequency of Oversight/Monitoring: DMRS regional office case managers will contact each participant and review the ISP no less frequently than once a month, and will conduct a face-to-face interview at least quarterly. DMRS regional office case managers also will receive and review monthly FA-generated budget status and expenditure report. As part of this oversight/monitoring, the DMRS case manager will review the performance of the supports broker with the participant.

Financial Administration:

1) **Activities to be Performed:** Bill MMIS through DMRS for participant-managed services in the approved ISP and manage participant accounts; disburse funds to providers while withholding appropriate deductions; review documentation of services including participant approval prior to payment; ensure that providers possess necessary qualifications, including conducting criminal background checks. Prepare monthly self-determination budget status reports for the participant/representative, supports broker (if applicable) and the DMRS regional office case manager.

2) **Specific Responsibilities:** The participant is the employer of record; the FA entity furnishes services to support the participant serving as the employer by ensuring that appropriate taxes and fees are deducted from individual provider payments and funds are disbursed appropriately. The FA entity is responsible for obtaining verification from the participant that services have been performed before initiating payment.

Employer of the Worker:

A. Who is Responsible for Payroll Tasks?

Financial Administration entity

B. Who is considered the Common Law Employer (Employer of Record)?

Participant or participant's guardian or conservator

C. Who is considered the Managing Employer?

The participant or the participant's guardian or conservator manages and supervises the worker and the work schedule, and the Financial Administration entity manages funds disbursement based upon: (a) approval by the participant or the participant's guardian or conservator of work performed and the worker's time sheet and (b) federal, state, and local tax withholding requirements.